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AUTHOR Meehan, Jane Pamela
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ABSTRACT

In response to the growing trend of using unlicensed assistive personnel (UAP) in hospitals, a study was conducted of faculty of associate degree nursing programs in New Jersey to determine which professional tasks they considered inherently safe for registered nurses to delegate to UAPs. A check-list survey was distributed to 104 faculty members at 13 nursing programs in the state, receiving responses from 48 teachers representing all 13 colleges and the major areas of nursing practice. An analysis of responses revealed the following: (1) among traditional tasks, those declared unsafe to be delegated by 50% or more fell into the categories of assessment and safety, emphasizing bacteriological, chemical, mechanical, and emotional safety; (2) only 10 out of 97 traditional tasks were deemed unsafe; (3) 55 of the traditional tasks garnered 90%-100% approval for delegation, while the 12 tasks that received 100% approval involved unit supportive tasks not directly involving patient care; (4) a total of 87% of 53 non-traditional tasks were deemed unsafe to delegate to UAPs; (5) for the non-traditional tasks, all 19 items dealing with asepsis were deemed unsafe by respondents, as were all 17 items dealing with safety and 10 items related to assessment; (6) the highest approval rating for a non-traditional task was using a UAPs report of patient temperature as the basis for administering an antipyretic: and (7) 56% of the faculty felt that UAPs should be certified and 65% desired state registration. (Contains 46 references.) (A cover letter and the survey instrument are appended.) (MAB)

AMATEUR NURSING: DELEGATING NURSING TASKS TO UNLICENSED ASSISTIVE PERSONNEL

Jane Pamela Meehan MSN, RN
Bergen Community College
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Prof. Theodore Rabb
Director,
Mid-Career Fellowship Program
Princeton University

PREFACE

Something was terribly wrong with my friend. Connie* was ill. The smile that usually dressed her face was gone. It had been replaced by twisted trembling. "Not. Not." she mumbled. Her charm and wit had vanished and she was bent with anxiety. "I'll sorry." Tears coursed down her cheeks. I had seen her the day before, puttering around her garden, a slender, alert eighty-four year old. This change was dramatic.

The doctor and I agreed to meet at the emergency room in the local hospital. The admission process went smoothly because Connie had all her documents at hand, a reflection of her orderly life. After a short examination the triage nurse took us to a small cubicle. Connie became a patient. She was placed on a stretcher, robed and tagged.

Ten minutes later a young women in white entered. She did not introduce herself but she was wearing several chains around her neck one of which spelled out "Susan" in large letters. "Susan" collected the leads for the monitor equipment and approached Connie. Startled, Connie resisted. "Lie still!" were the first words we heard from "Susan". Quickly I explained to Connie what was happening and asked "Who are you?"

"I'm Susan." The woman answered.

"I knew that from your necklace." I am a nurse educator and would have had stern words for any student who did not explain to their patient who they were and what they were doing, especially one as confused and anxious as Connie. "What is your position here?" I asked.

"I'm an Emergency technician," she answered accenting emergency.

"Where is our nurse?" I was nervous because Connie was less able to talk than earlier in the day. Susan did not respond, she was adjusting the monitor screens. All our eyes turned to the screens. "You don't know what you're looking at!" Susan challenged.

"Actually I do. I teach nursing." I had difficulty controlling my voice. I was alarmed and angry. "Everything looks normal for Connie except the oxygen saturation level. Check the connection. Sixty-eight percent is incorrect. Her breathing and color are too good for that reading." My voice took on the commanding tone I use when I want a quick response.

*All names used are fictitious.

Susan did as I asked.

Three hours later we had seen the trauma doctor, the family physician and the neurologist called in to consult. But we had not seen our primary nurse.

Connie was taken to x-ray for a CAT scan and I sought out the charge nurse. I explained the events that had taken place and asked why we had a surly technician inflicted upon us. The charge nurse, a former student of mine, sighed and explained that due to "economic realities" there had been "downsizing" and experienced nurses replaced with unlicensed technicians who had been "cross trained" in various tasks over an eight week course taught at the hospital.

I was surprised and explained that I knew nothing of this new "restructuring" and felt that Connie had been placed in jeopardy. The charge nurse agreed.

My friend Connie recovered. I did not. I was haunted by the experience.

INTRODUCTION

The utilization of aides for health care has a long history in the provision of patient care (Brider; Phippen and Applegeet 455). Nurses have been delegating care activities to family members and various trained aides since the beginning of the profession. During the early 1900s, in the United States, controls were placed on nursing education and practice in an effort to safeguard the public health (Ellis and Hartley 125). North Carolina, followed quickly by New Jersey and New York, was the first state to write nurse practice legislation which regulated nursing education and required licensing for practice (Ellis and Hartley 126).

When large numbers of non-professional workers joined the health care team during the 1940s and 1950s, registration and licensing was imposed upon the workers and guidelines were established for the educational institutions which trained them.

Today, the practice of nursing requires sophisticated scientific knowledge and high levels of technological skills. The legislation for nursing practice was adjusted over time to meet the perceived need for consumer protection. A licensing examination and background check were instituted and recently provisions have been added by most states for advance

practice rules and requirements for continuing education (Ellis and Hartley 124-134). The licensed practical nurse, dental hygienist, respiratory therapist, etc. were also required to take national examinations and the schools were required to be accredited by professional and state agencies. Eventually, nurse/home health aides were registered or certified, as federal laws required standards for agencies which were recipients of Medicare funding(Ellis and Hartley 380). Therefore, the arrival of unregulated, unlicensed assistive personnel (UAP), within the health care team, alarms professional nurses.

During today's economic difficulties many hospitals and health care agencies are training greater numbers of UAP to perform complex nursing tasks without the benefit of the science which clarifies and informs judgment (Driever 2-8; Curry 428). The nursing profession has incorporated three different educational programs for professional nursing: diploma, associate degree and baccalaureate degree. The rationale for the two college programs was that the Associate Degree Nurse (ADN) would be the professional technical nurse who would replace the diploma graduate. The ADN graduate would work under the direction of the Baccalaureate Degree Nurse (BSN). However, the ADN was never utilized according to design and the profession has presented a scattered image (Ellis and Hartley Chp. 2). Therefore, it is not surprising that administrators of hospitals and other health care agencies choose to see nursing, not as an integrated interpretative and judgmental activity, but, as piecework. This view has led to the diversion of nursing tasks from professional nurses, and the employment and training of UAP (Ketter).

The nurse practice act of every state holds the registered nurse accountable for all patient care including those tasks delegated to assistive personnel (Miller). The practice acts require that a nurse, who delegates a task to another person, knows the education of that individual; knows their competence; supervises and inspects their work, and evaluates the outcome of the task (Miller). Because hospitals control the education of UAP, set the rules for delegation, and have no external oversight of training practices, many nurses find themselves in the position of having to delegate tasks which they consider too complex (Gordon). A consumer of health care is well advised to ask: "Who is that person at the bedside or in the clinic who is wearing white?" More and more the answer is a

technician with eight weeks of training. This situation is of great concern to all nurses. This situation should be of concern to all health care professionals. This situation should alarm health care consumers.

REVIEW OF THE LITERATURE

A computer search of the literature covering the years 1989 - 1994 was done using Medline and CINHAL. Empirical studies related to the selection and evaluation of specific nursing tasks by educators were non-existent. The articles available presented anecdotal information, similar to that found in the Preface and a limited number of descriptive studies which dealt with saving costs; tasks incorporated within the traditional and non-traditional extended role of UAP; and nurses' and patients' response to the introduction of traditional aides and UAP within patient care units.

Traditional Assistive Role:

Early studies which focused on the traditional aide role included Merker et al. who delineated several titles for assistive personnel; orderly, aide, janitor, and unit clerk. Anecdotal reports were used to assess Registered Nurses' (RN) satisfaction, financial impact, patient satisfaction and quality of care. All hospitals reported positive responses in all areas assessed. Because anecdotal and retrospective data was used the results can not be generalized.

Sheedy, (using the term unit hostesses), Hesterly and Robinson found in their studies that using aides was helpful and cost effective. The aides, described in the studies, had the job of delivery of nourishment, unit supplies, patient mail, and items requested by patients, as well as answering lights and phones, but did not include patient care. The surveys of staff found that patients were less anxious and that Licensed Practical Nurse (LPN) and RN staff reported less stress in carrying out their jobs. The nurses reported difficulty in delegating tasks to others and needed education in leadership and management strategies.

The use of more sophisticated aides, e.g. LPNs and nursing students, who do basic patient care such as bed baths, would be expected to decrease the nurse-patient care loads, and increase staff and administrators satisfaction. However, when these nursing assistants and LPNs were added

to the nursing team the overall quality of care was reported as less, and both RNs and assistants proved to have higher numbers of sick days with the non-professional staff reporting ill more often than the professional staff. The RNs did report having more time with patients but had some difficulty in delegating tasks to nursing assistants. The authors related nurse dissatisfaction to an increased rate of nurse turnover (Jung; Powers et al.).

The traditional role has been described in the literature as containing non-patient tasks; secretarial, housekeeping, janitorial, transport etc. and basic patient care, bed baths, bed making, assessments of temperature, pulse etc. These studies report high acceptance of this assistive role by patients, staff and management.

Non-traditional Assistive Role:

Manthey (1989, 1989a, 1990), Clark and Hollander studied the teaming of auxiliary workers and RNs. Using Manthey's partnership model, the assistants and RNs agreed on a work relationship which was formalized. The assistants could be LPNs, technicians, and/or traditional aides. The authors found that patient-nurse ratios were able to be safely increased without RN dissatisfaction or loss of quality of care. The nurse and assistant worked as a team sharing patient care with the net result that RNs spent less time with basic care tasks. The indicators assessed were increased number of admissions processed, completion of nursing care plans, and nurse self-reports of satisfaction.

An extended role for LPNs was described in a study by Fortin et al. The LPN was assigned to dressing changes, medication administration, including intravenous solutions. Most of the basic care was delegated to aides. The redesign of work into districts, with teams of RNs, LPNs and traditional aides, provided increased time for RNs to carry out professional work. Satisfaction was reported as high by self-report of nurses involved. The role for the LPN in this study was similar to the role described in recent reports for UAP who receive six to eight weeks of training (Abts et al.). The LPN is licensed and receives 52 weeks of education.

The introduction of patient-care technicians and cross-trained nursing assistants occurred during the late 1980s. Studies were carried out which described the cost effectiveness, patient satisfaction, and job satisfaction,

as they compared with the traditional model for assistive personnel. These UAP were given, on average, six to eight weeks of training which prepared them to assume selected nursing tasks e.g. dressing changes, suctioning, Foley catheterization, EKG recording, intravenous fluid set-up, and blood drawing (Brider; Manual and Alster; Milstead). The aforementioned studies drew conclusions based upon dollars saved by reduction in RN positions, and elicited statements of nurse satisfaction, some of which were gathered by administrators. Therefore, these findings are difficult to evaluate.

W. D. Crawley, R. S. Marshall and A. H. Till describe the restructuring of hospital staffs with the incorporation of UAP in an effort to offset nursing shortages and/or expenses associated with nursing care delivery. The article clearly spells out tasks which the authors believe are appropriate for UAP with eight weeks education. Added to the traditional role are measurement of blood pressure, feeding via nasogastric and gastric tube, suctioning and tracheostomy care, turning, coughing and deep breathing exercises, monitoring incentive spirometry use, application of nasal cannula and mask oxygen, specimen collection for gastric secretions, documentation on flow sheets, (patient care flow sheets, diabetic care sheets etc.), Foley and condom catheter care and maintenance. The authors believe that if there is clear delegation of tasks with oversight by an RN who regularly supervises and works with the UAP there will be financial gains and greater work efficiency.

The Cawley et al. study also alludes to measures which would expand the UAP role. Through further training more complex tasks could be taught. They point to the recommendation of the American Hospital Association that housekeepers can perform EKGs, blood drawing, and transportation of the patient! So this individual might go from taking care of dirty waste to drawing blood from a patient! Without benefit of a course in bacteriology, which emphasizes principles of infection transmission, the germ theory, and the critical need for proper handwashing, one has established a recipe for infection. This is just the kind of problem the American Nurses Association (ANA) identified on page one of their position statement: "...concern that in virtually all health care settings, unlicensed assistive personnel are inappropriately performing functions which are within the legal practice of nursing" (Driever 37).

Cawley et al. included job descriptions from the Medical College

of Georgia Hospital because clear explanations of UAP duties are essential for their successful incorporation. The researchers found an association of role confusion with loss of morale and rising stress among health care team members. The utilization of multiple task training was not evaluated in terms of the lose of the benefit that accompanied the single task roles, frequent and repetitive task practice which increased efficiency and skill. How many times will the housekeeper take out the garbage versus draw blood? Which task will he/she become most skilled at? While there is mention of appropriate delegation there is no mention of appropriate outcome research or pilot studies or any other protection of standards.

Niedlinger et al. carried out an experimental study. The authors looked at changes occurring in a 560 bed medical center when Manthey's partnership model was introduced. A pilot study was done using four units: two as the control units and two as the experimental units. The UAP were paired with nurses after two days of classroom orientation. The education program planned for a two week unit orientation period and ten week clinical supervised practice. The tasks to be delegated were similar to those described in the Cawley study. The research team monitored the activities of the nurses and UAP. The results reported that personnel costs for both units increased with the increase for one of the experimental units being exactly twice that of the paired control unit. The explanation given was that patient population was not constant in terms of acuity. Interestingly, registry/contract nurse costs were reduced by 61% to 73% but overall costs rose. Unit quality audits reported a decline from 97% compliance with standards to 81% - 84% after implementation of the program. Knowledge, trust, communication and RN experience were cited as both a help and a hindrance to UAP - nurse working relations. The two factors underlined were that the role of the UAP and the delegation of tasks must be made clear to RNs. The supervision of UAP was reported as more burdensome than helpful by many of the nurses.

Lengacher et al. reported a collaborative study with nursing service administrators and a local college. A 35 bed unit was utilized for development of a model for care. Quality indicators included intravenous infection rates, medication errors, skin integrity, falls, and patient satisfaction. Indicators of productivity included cost reduction, documentation time, report time, and overtime reduction. Nurse satisfaction

was assessed by turnover rates, reports of staff, and retention rates. Multiskilled UAP were placed under the direction of RNs. Prior to the introduction of the new model, several classes per week were held with RNs to discuss the anticipated changes in the practice environment and the process of delegation of tasks to UAP. The education of the UAP included three weeks for fundamental skills, two days for respiratory therapy, one day for physical therapy, nine days for EKG and arrhythmia interpretation, two days for phlebotomy and two weeks of clinical practice. Patient - nurse ratios were able to be raised from five patients per nurse/UAP partnership, on the day shift, to seven patients per partnership (RN and aide). Similar changes occurred on the evening and night shifts. Costs remained constant with the new model. Nurse satisfaction was rated higher "because nurses were given a new career ladder" and had spent more time on "essential professional role activities". Findings in regard to delegation were similar to those of other studies, in that nurses needed more education to effectively carry out delegation of tasks to UAP even after preparatory classes. Nurses requested to be trained in the same EKG, phlebotomy etc. tasks as the UAP so that they could supervise them more efficiently. Finally, nurses needed more time with supervisors to discuss their feelings. Assessment of post intervention measures, e.g. infection rate, fall rate, errors, etc. were to be determined after the first year and were not available.

M. A. Blegen, D. I. Gardner and J. C. McCloskey carried out a survey of 1445 nurses across the USA. The survey was published in the April, 1991 American Journal of Nursing. While the population was self-selected it was large and represented nurses working in acute care hospitals and long term facilities. The nurses were positive in their responses to the need for assistive persons, citing heavy workloads. The responses were mixed on what should be delegated. The nurses were less conflicted about those tasks which they felt should not be delegated than those which should be frequently delegated. They cited obtaining lab data from computers, checking electrical equipment, changing wound dressings, and performing urinary catheterizations as reserved for nurses. Basic bedside care such as baths, linen changes, were easily agreed upon as able to be delegated, but confusion and disagreement occurred when EKG performance, answering pages, applying traction and other specialty tasks were discussed.

D. G. Huber, M. A. Blegen and J. C. McCloskey (1994) wrote a follow-up article describing the comments received with the AJN survey. A large number of nurses, 885 or 61%, wrote comments. Four major themes were included in the comments. One, confusion exists among nurses and UAP about which tasks should be delegated. Two, nurses stated that the UAP needed more education. Three, nurses stated that they need workload relief. Four, nurses voiced concerns about the quality of patient care when UAP were added to the staff. The summary idea was that "profession-wide policies for education, utilization, and regulation of assistive nursing personnel must be developed". The authors pointed to position papers written by the Tri-Council for Nursing, Joint Commission on Accreditation for Healthcare Organizations, American Hospital Association with the American Organization of Nurse Executives, National Council of State Boards, and the American Association of Critical - Care Nurses which offered similar concerns about the potential and actual inappropriate use of UAP.

A review of the literature by the British authors Dewar and Clark reported on changes in delivery of nursing care with "nurse helpers", an equivalent to UAP, replacing students as primary aides for nurses. Research relating to attitudes by Cole, Hardy, Pearson and Purdy found resistance to the introduction of increasing numbers of auxiliary workers. These studies were anecdotal in nature and as Chapman points out, revealed that the overwhelming feeling reported by RNs was anxiety. Specifically, RNs worried about which tasks to delegate to helpers while preserving patient safety.

Nurse helpers, on the other hand, interviewed by Cole were very enthusiastic about taking on expanded roles in patient care. These workers felt that they were capable or even currently doing the jobs in question. The study was small, twelve subjects, however, it pointed out that there was friction between nurses and helpers similar to the role conflict sometimes seen between nurses and doctors.

The Department of Health and Social Security of the United Kingdom reported that the nurse helpers made up one-third of the work force in health care. This staff mix is similar to that presently found in the USA in the west and south (Abts et al.; Belgen et al.). In both countries indirect services, (no patient care), housekeeping, diet aides, clerks etc. and basic care aides, who deliver basic patient care, e.g. bed baths

and bed making services, were well accepted, saved time for professional nurse activities, and caused little conflict or anxiety among health care workers and patients.

In Britain during the early 1990s there was a shift and expansion in job descriptions for nurse helpers toward more complex tasks which paralleled that seen and reported in the USA (Bolger). A study was carried out by Ball and Goldstone to ascertain quality of care with the new skill mix, (advanced helpers and nurses). This study looked at newer management systems for nursing, activity analysis and survey of opinions of RNs regarding the skill levels needed for the new helpers. One hundred ten skills were delineated and a survey was issued to eight health authorities. There was a 95% return rate. The results obtained demonstrated that 18% to 28% of nurses' time was spent on non-nursing tasks such as transport, errands, cleaning, etc. Speculation about nurses retaining non-nursing tasks included the comments by Menzies that nurses used non-nursing tasks to "cool off" or "reduce stress" associated with difficult nursing activities. The nurses observed in the study sought to retain traditional nursing actions such as medication administration and sterile procedures as well as all vital sign assessments, and collection of specimens, (75% agreement). Explanations by the subjects for not delegating low level tasks included the unidentified value of non-nursing tasks as camouflage for cognitive and psychological therapeutic actions on behalf of patients, providing opportunities for teaching and allowing for extensive data/assessment collection. This study while supplying some insight into task delegation, gave no information about quality of care achieved.

The British researchers acknowledged the limited results of their studies and identified the need for extensive investigation into the areas of organization of work roles, task delineation for helpers, and clearly stated training guidelines for helpers.

The major findings in this review of the literature: the kinds of tasks delegated to traditional and extended or non-traditional unlicensed assistive personnel; need for education of RNs in the areas of delegation of tasks and leadership; need for clear definition of UAP responsibilities; the belief of nurses that they should retain all complex tasks as well as those which allow contact with patients for data collection, support and teaching activities; and the need for longterm studies which focus

on patient care outcomes, costs, absenteeism, successful methods of RN delegation, and evaluation of the knowledge and performance of UAP.

PROBLEM STATEMENT

What traditional and non-traditional tasks do the faculty of the New Jersey Associate Degree Nursing Programs designate as inherently safe for registered nurses to delegate to unlicensed assistive personnel?

EXPECTATIONS

Taking the tasks reported in the literature, listed in local hospital job descriptions for UAP and the State Practice Act of North Carolina and pending Pennsylvania nurse practice legislation, a survey was constructed to seek faculty consensus on tasks which are inherently safe for registered nurses to delegate to UAP in situations where patient conditions are stable and predictable. The assumptions for the study were that the UAP were taught by registered nurses, that the decisions should be made on the basis of the complexity of knowledge inherent in the task itself and that the tasks:

1. were routinely performed in the daily care of the patient;
2. were clearly organized into an accepted sequence of steps;
3. were performed with the expectation of a specific, defined outcome;
4. did not require continuing or changing assessments or decisions which were beyond the task itself;
5. have been validated by the RN as within the abilities of the UAP (North Carolina Nurse Practice Act).

According to the literature those items listed as "traditional tasks" should be approved as safe for delegation by the majority of nurse educators. Those extended or "non-traditional" tasks which require understanding of the complex principles of medical-surgical asepsis, assessment, and safety, (emotional, mechanical, thermal and chemical) should be designated unsafe for delegation by a majority of nurse educators.

METHODOLOGY

The check-list survey of specific tasks appropriate for delegation to unlicensed assistive personnel was pilot-tested by twelve of the nursing program faculty at Bergen Community College. Revisions and additions were made to the survey which took the form of separating related items and clarifying tasks with descriptive terms.

The revised survey was distributed to each of the remaining thirteen Associate Degree Nursing Programs in New Jersey after seeking the cooperation of each program chairperson by telephone. See Appendix for cover letter, definitions and survey with raw scores.

The faculty population possesses the requisite knowledge and experience in the teaching and practice of nursing to make the judgments necessary. Furthermore, because ADN faculty teach psychomotor skills to the uninitiated learner, who usually holds only a high school education of variable vintage, and do not have economic or political ties with health care institutions and/or insurance companies, they are the population best equipped to address the survey with authority and objectivity.

While there is a similarity between the learners there is less similarity between the learning experiences of ADN and UAP students. The ADN student is exposed to supportive science courses which run concurrently or prior to the introduction of difficult skills; have multiple opportunities to practice with supervision in labs and hospital settings; have enriched learning environments with access to large libraries, films, computer programs and interactive videos, and the luxury of four or five semesters to master a similar list of skills. UAP learning takes place mostly "on the job" in clinical areas under the direction of preceptor RNs. The list of skills is similar, not comparable, because many hospitals do NOT allow nursing students, even under the direct supervision of experienced faculty, to perform any procedure related to venous blood drawing, anticoagulant blood assessments, access to, dressing changes of, or discontinuance of central lines. Yet UAP are expected to master these skills in a matter of weeks.

RESULTS

There were 104 surveys distributed and 48 were returned within four weeks time. The respondent population represented all thirteen community colleges and was comprised of 47 females and one male who ranged in age from 32 to 65 years with an average age of 45.3 and a median age of 48. Each major area of practice, medical-surgical (N = 22), pediatric (N = 9), obstetric (N = 9) and psychiatric (N = 8), was represented. All but one of the faculty possessed a Masters degree or greater the distribution indicating: one BSN, thirty-nine MA/MSN, seven Ph.D/Ed.D. and one non-respondent. Most of the respondents held professorial rank i.e. twenty-one assistant professors, eighteen associate professors, and three full professors, five instructors, and one not responding. Teaching experience reported ranged from 2 to 40 years with an average of 15.75 and a median of 15.5. Years of practice reported ranged from 3 to 40 with an average of 21.6 and a median of 19. This sample population represented senior faculty with the appropriate credentials and experience.

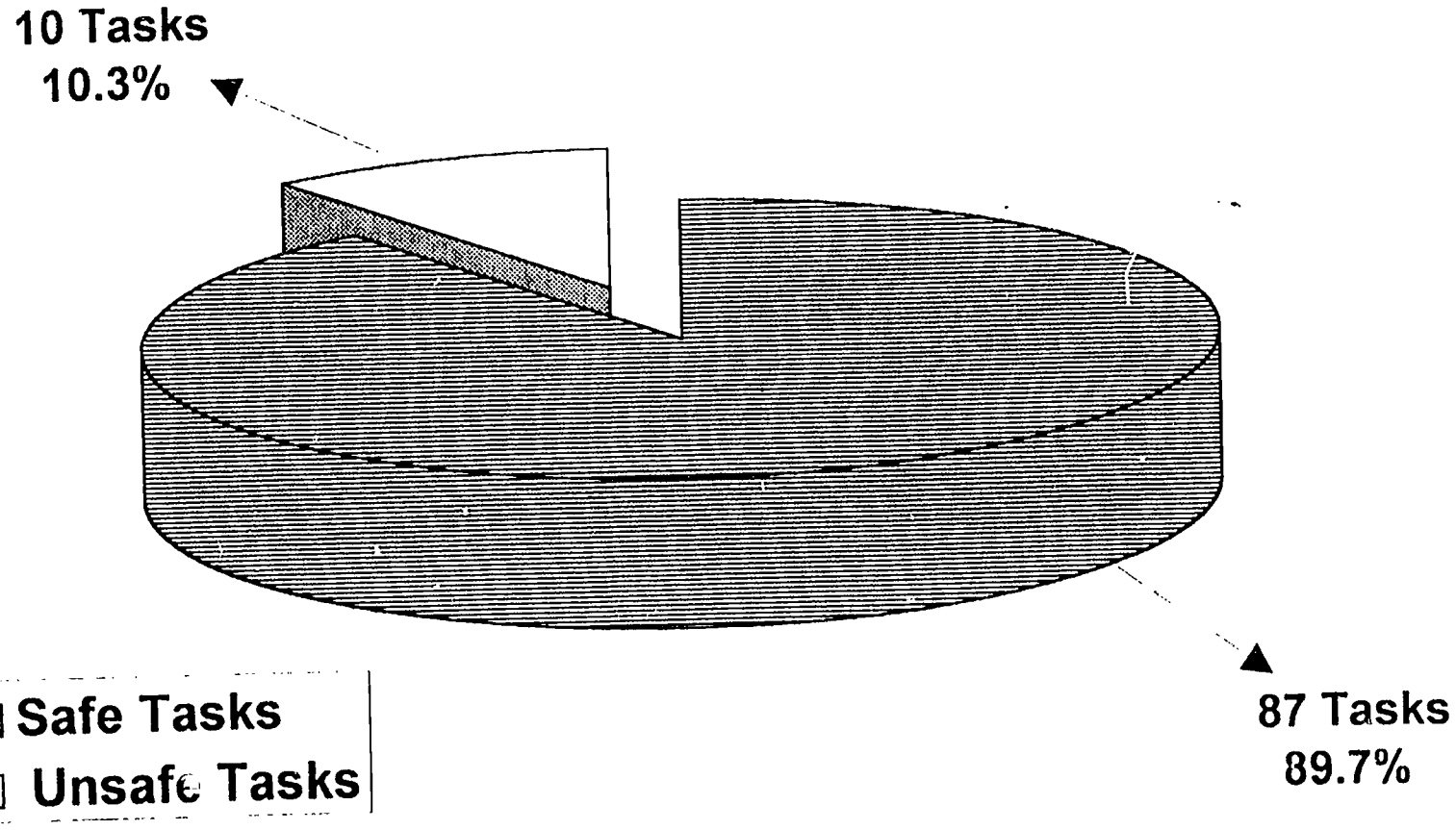
Responses to Traditional Tasks 1 - 97

Assuming a simple majority as the definition of a "safe task", (50% or greater "Yes" responses), and of an "unsafe task", (50% or greater "No" responses), the results were tabulated. The tasks found to be unsafe fell into two broad categories: assessment and safety with subgroups under safety being bacteriological, chemical, mechanical, and emotional. Because the data related to asepsis was so large they were culled out of the safety category.

Responses to the traditional tasks were highly positive, as expected. Faculty found very few tasks, a total of ten out of the 97, unsafe to delegate (see Exhibit A). Tasks which were found to be unsafe by a majority of respondents, with disapproval ratings between 50% and 79% were items: 35 and 36, which related to asepsis specifying emptying wound drainage from sterile drains, and items 91 and 92, changing dressings; tasks 38, 40, 41 related to instillation of tubes/fluids, and 84 and 87 requiring application of heat, could be considered mechanical and thermal safety hazards; the last task, 48, called for using assessment and asepsis when recording and measuring wound drainage (see Exhibits B and C). Two items,

Exhibit A

Distribution of Traditional Tasks



91 and 92 which specified decubitus care and dressings received the highest number of 'No" responses, 79.2%.

There was unanimous agreement upon twelve of the traditional tasks as safe to delegate: items 1, 2, 6, 7, 8, 9, and 14, all of which were unit supportive tasks and did not involve direct patient care; 22, aid in dressing and undressing patients; 51, transfer of patients to chair/stretcher; 63 and 64 checking side rails and answering lights; and 70, universal precautions, were related to basic assistive care for patients.

Forty-three Traditional tasks garnered 90% to 99% rates of approval. These included items: 3 - 5, 10, and 12 secretarial and supportive tasks; 15, and 18 - 20 tasks which fell under the label basic hygiene; 23 - 25, 27 and 28 nourishment activities; 29, 30, 34, 46, and 47 tasks related to helping patients with bathroom, bedpan, urinal elimination; tasks 50, 52 - 59, required moving patient in bed and around the unit; 66 - 69, and 73 tasks related to patient safety such as handwashing, CPR certification, etc.; and special procedure items related to assessing temperature, pulse, blood pressure, respirations, weights, etc., (items 74, 75, 77 - 79, 82, 88- 90, and 97). In total, 55 of the 97 traditional tasks were approved as safe by 90% to 100% of respondents.

Sixteen items received an approval of 75% to 89% : 11 and 13 secretarial tasks dealing with recording of doctors' orders and scheduling tests; 16, 17, 21, and 26 tasks related to baby bath, sitz bath, nail care and offering and restricting fluids; 31, 32, 37, 45, and 49 were tasks dealing with collection of specimens, hygiene, condom catheter application, recording output, and weighing diapers for output; 71 using hat, gown, gloves and masks for working in isolation areas; 80, 81, 83 and 95 tasks labeled special procedures requiring assessing adult/baby weights, reminding patients to cough and deep breathe, and application of support hose. These tasks resting in the top quartile were heavily weighted toward non-patient contact and excluded all complex tasks.

The items which fell between 50% and 74% approval were: 33, 39, 42 - 44 tasks requiring hygienic care of Foley/suprapubic catheter, administering a Fleets enema, and maintaining gastric suction equipment by draining apparatus and changing tubing tasks which require a greater degree of ability because accuracy of measurements are critical and dislodging of

Exhibit B

Traditional Tasks Designated Unsafe by The Majority: Asepsis & Assessment

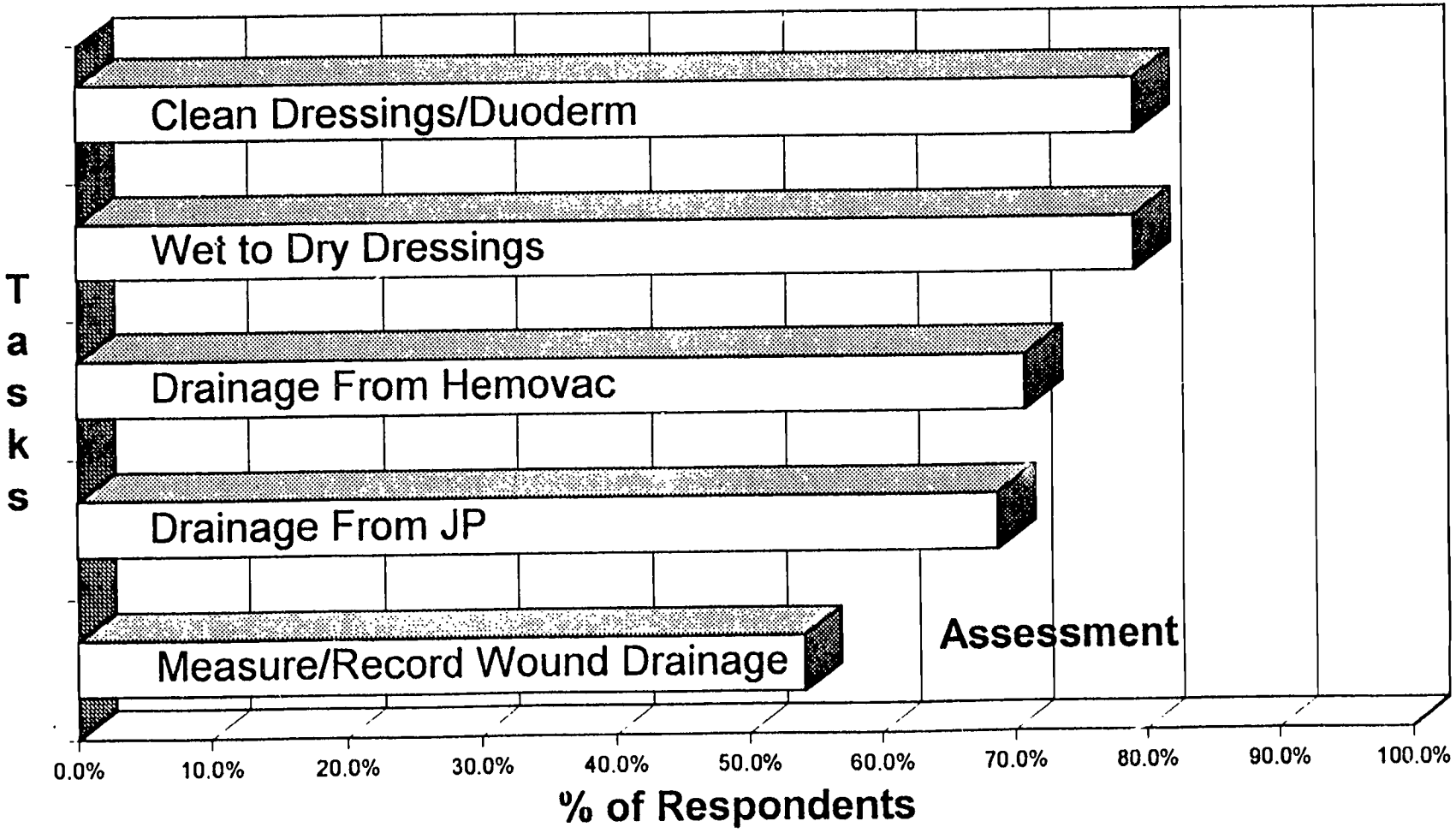


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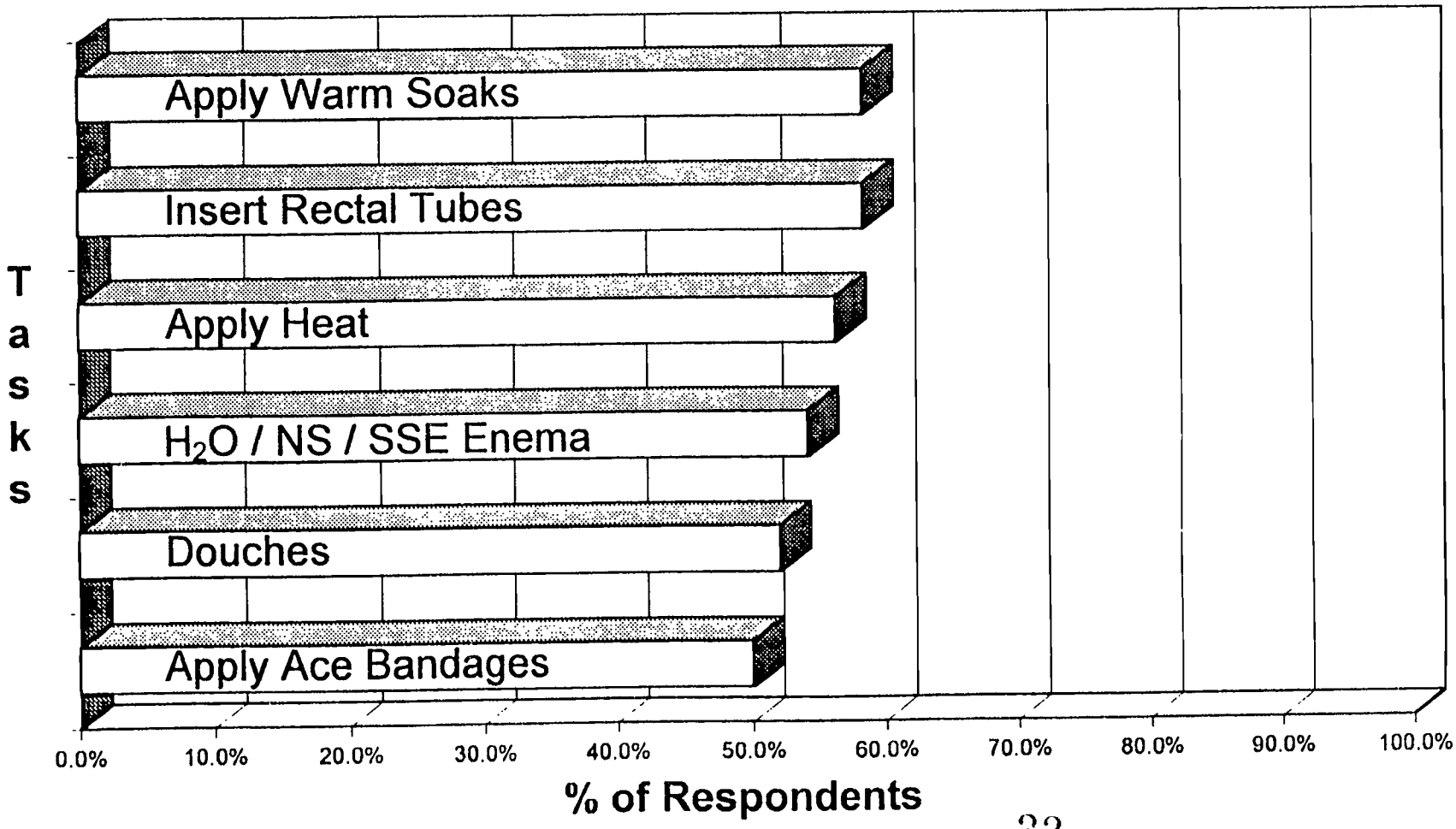
Exhibit C

Traditional Tasks Designated Unsafe by The Majority: Safety



tubing or drains must be prevented; 60 - 62 application of restraints, slings, venous compression devices and range of motion; 72 using sterile gloves which implied an isolation or sterile procedure; 76 assessing an apical pulse; 85 - 86 application of warm and cold; 93 - 94 skin prep for surgery, ace bandaging and 96 applying abdominal binders. Interestingly, a total of 87, or 90% of the traditional tasks were considered safe by a majority of respondents.

The tasks designated as safe are similar to those found with high approval in the literature. Those tasks determined as unsafe, with 50% or greater disapproval, could be described as requiring a greater degree of integration of principles of assessment, asepsis, and thermal, mechanical, and/or chemical safety. Comments added to the survey suggest that the respondents felt that many ordinary tasks required greater amounts of assessment because of the high acuity of even stable patients. One person asked: "Where are these stable, routine patient situations?" Another reminded: "Don't underestimate the real work of nursing, ongoing patient assessment."

Responses to Non-Traditional Tasks 98 - 150

The non-traditional items which were denoted as unsafe were enormous. A total of 46 tasks out of 53, 87%, were disapproved by 50% or more of the respondents, almost the exact opposite finding with the traditional tasks (see Exhibit D). Looking at the data one is struck by the accumulation of 20 tasks (40%) which received between 90% - 98% "No" designation by the respondents. Another 13 tasks languish in the 76% to 89% disapproval range. These tasks are displayed by category with asepsis being the largest grouping (see Exhibits E, F and G).

All nineteen items which fell under the heading asepsis (Exhibit E) were scored unsafe within the 71% to 98% range: items 106 - 111 care and suctioning of tracheostomies; 116, 118 - 121 requiring dressings and discontinuance of intravenous; 122 finger stick for capillary blood specimen to assess glucose level; urinary catheter instillation, irrigation and specimen collection; and dressings/irrigations of wounds. Faculty who wrote comments stated that all sterile procedures and most invasive procedures belonged in the hands of nurses.

Seventeen safety items (Exhibit F) were disapproved: 105 drawing

Exhibit D

Distribution of Non-Traditional Tasks

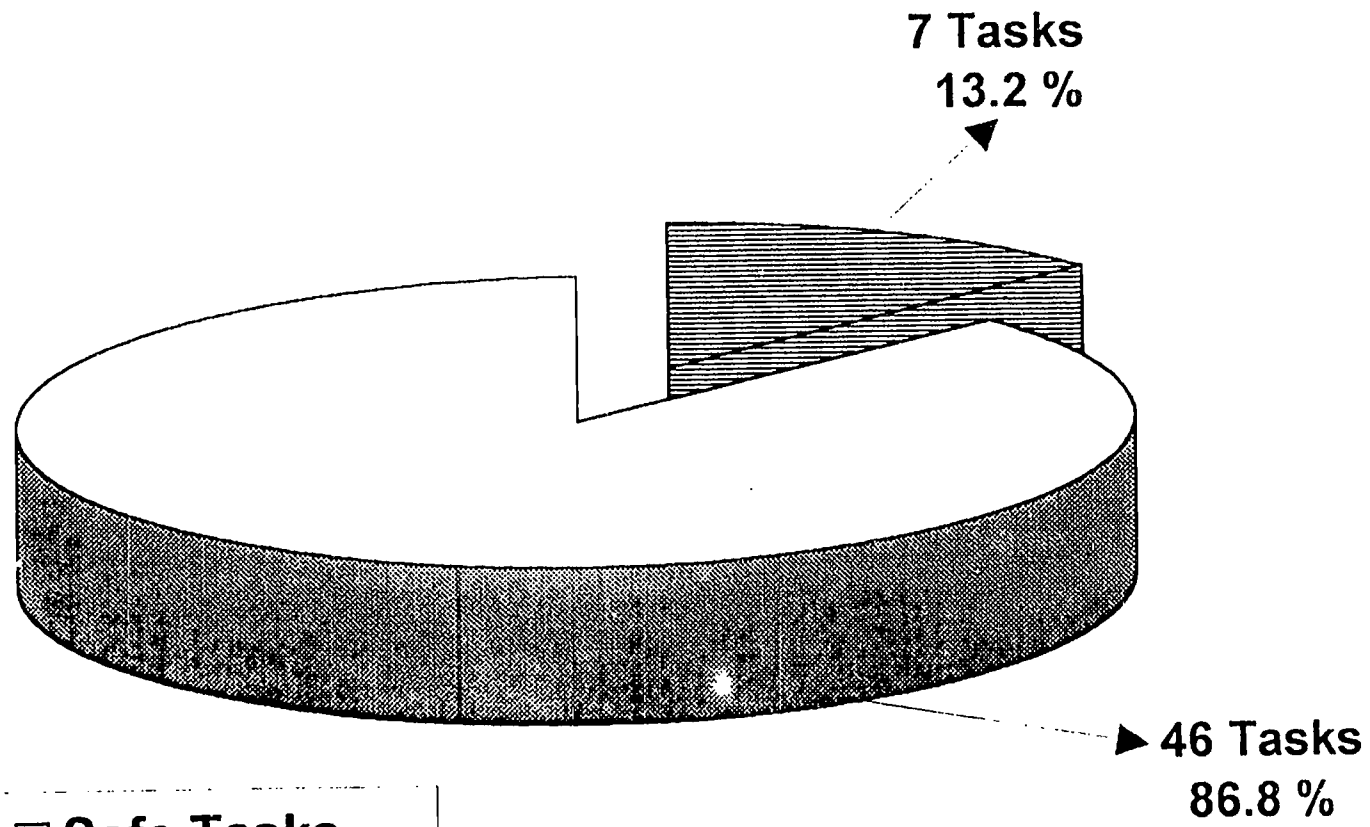
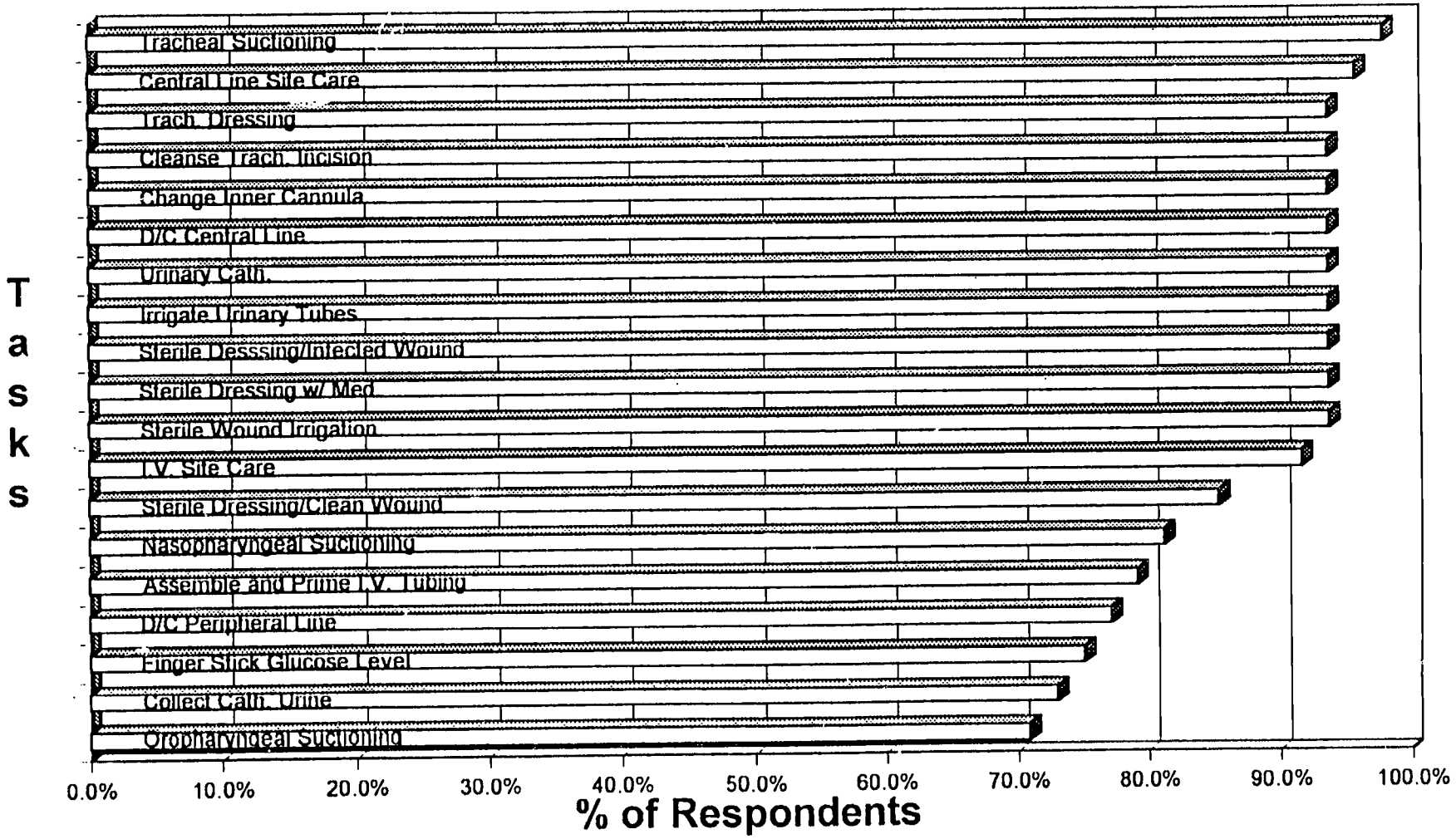


Exhibit E

Non-Traditional Tasks Designated Unsafe by The Majority: Asepsis



venous blood specimens; 112, 113, and 115 relating to instillation of nasogastric and gastric tube feedings and the discontinuance of these tubes; 126 - 128 ostomy care/irrigation and removal of fecal impactions can be considered threats to mechanical safety; 129, 130, and 132 care and observation of anxious, suicidal and secluded patients can be considered threats to emotional safety; and 138 -143 relating to medication administration can be considered threats to chemical safety.

Ten items relating to assessment (Exhibit G) were found to be unsafe by the respondents. The monitoring of oxygen via pulse oximeter or flow gauge, intravenous flow rate, EKGs, items 99, 101, 102, 104, and 117, and those items related to assessments prior to medication, 145 - 150 were strongly rejected.

It is clear that nurse educators are aware that the largest threats to patients are hospital acquired infections, secondary to improper asepsis and poor patient immune responses, and emotional, chemical and mechanical trauma.

Comments surrounding some of the items such as medication administration, tracheal suctioning and care, and dressing applications for central lines were: "NEVER!"; "infections rates will soar'; and 'this is dangerous and will not work".

The highest approval rating recorded for a non-traditional task was 73% for item 144, RNs using UAP's report of patient's temperature as the basis for administering an antipyretic. In all only seven items of the 53 or 13.2%, fell above the 50% level of approval. These tasks were: 144 mentioned above; 98, 100 and 103 for setting up a pulse oximeter, oxygen equipment and applying/removing EKG leads, 102 measuring a blood pressure and 14 clamping NG/Foley tubes which require only minimal patient contact; and care of confused and restrained patient, a task which has been well established with psychiatric technicians, many of whom possess a college degree.

The results of this survey indicate serious problems, in the minds of seasoned faculty, as to the inherent safety of tasks now commonly being delegated by RNs to UAP.

To establish consistency within the survey those items related to surgical asepsis and medication administration were checked within the traditional and non-traditional lists to determine if respondents chose

Exhibit F

Non-Traditional Tasks Designated Unsafe by The Majority: Safety

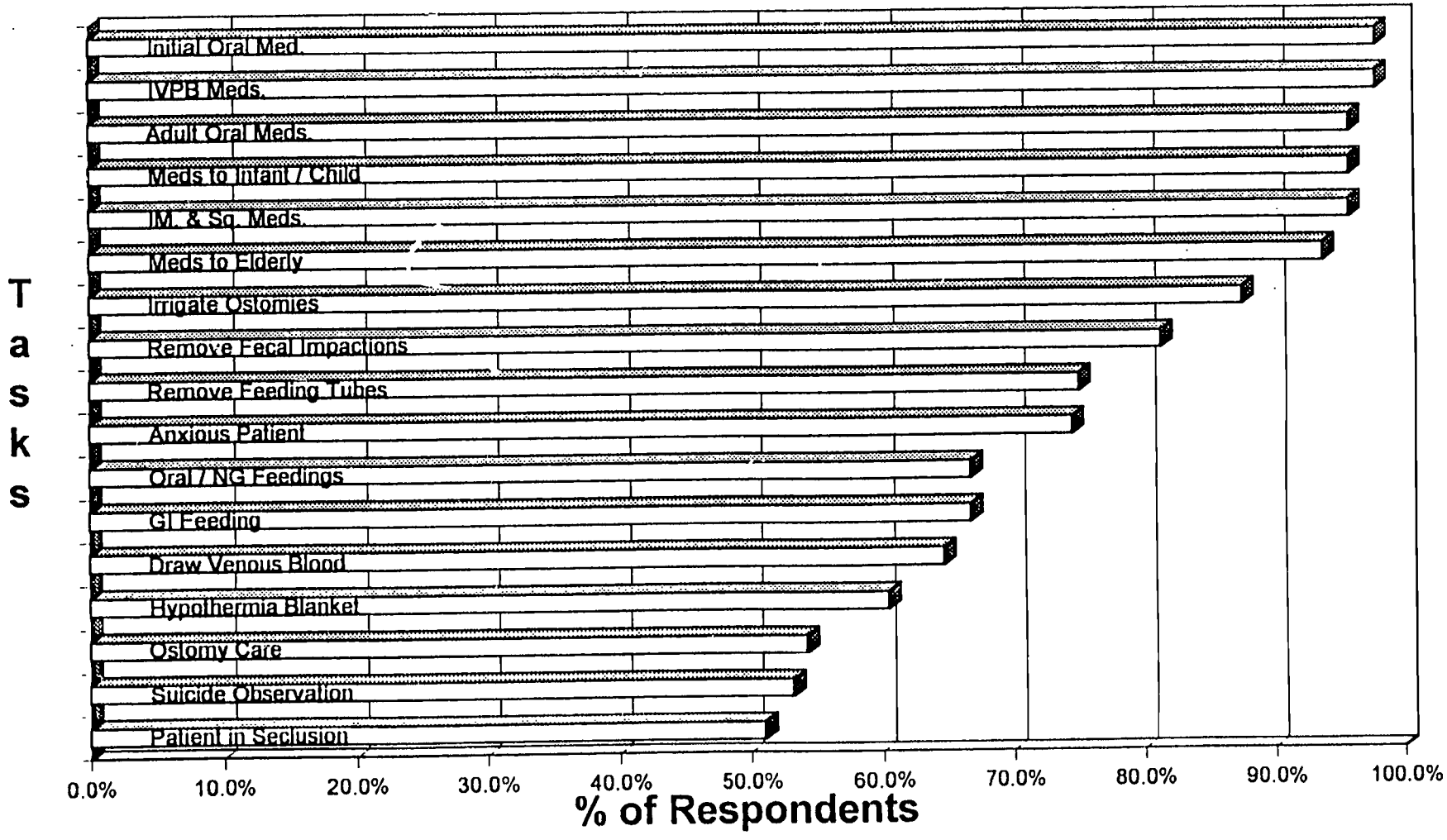
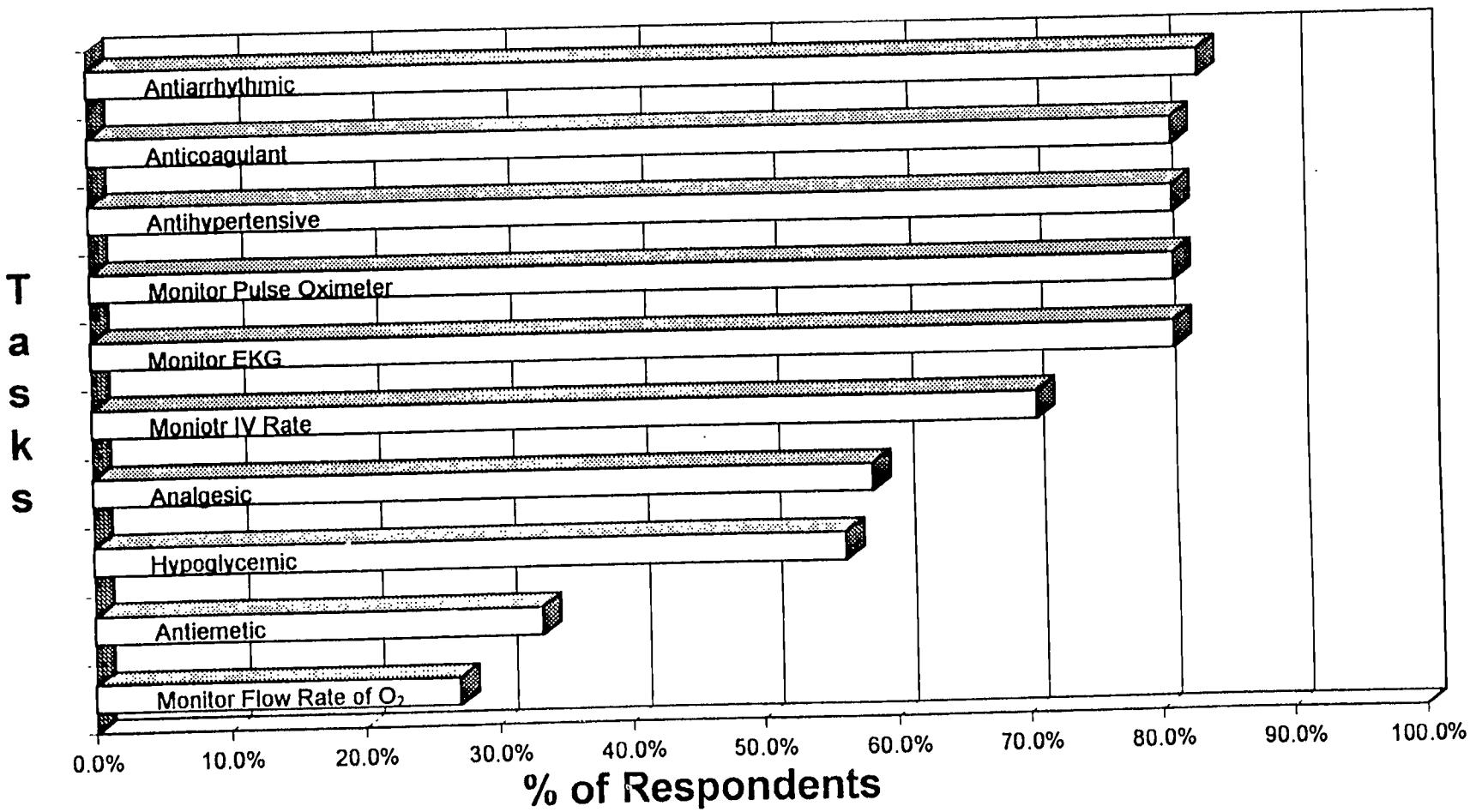


Exhibit G

Non-Traditional Tasks Designated Unsafe by The Majority: Assessment



the identical response on similar items. The responses to sterile dressings and medication administration were uniformly negative. When the practice questions, 144, 145, 147, 148 and 150, which asked the respondents whether they would rely on vital signs reported by UAP when administering a medication, were analyzed many respondents considered it safe for the UAP to perform the tasks of temperature, radial/apical pulse, blood pressure, and finger stick for blood glucose but would NOT accept the measurement taken as the basis for their practice.

CHART 1.

	Practice Question:	Yes	No	Task:		Yes	No
144	antipyretic meds.	35	13	74	temperature	44	04
145	antiarrhythmic meds.	01	47	76	apical pulse	28	20
146	analgesic meds.	09	39	no corresponding task			
147	antihypertensive meds.	08	40	102	blood pressure	32	16
148	hypoglycemic meds.	14	34	122	finger stick blood glucose	12	36
149	antiemetic meds.	20	29	no corresponding task			
150	anticoagulant meds.	04	42	included within 150			

The reaction to the practice questions 146 and 149 was negative but respondents were more strongly against providing pain medication on the basis of UAP reports then for accepting the description of symptoms of nausea before administering an antiemetic. When administering drugs the respondents would perform their own assessments. This is an indication that even when UAP are directed to carry out assessment tasks they will not diminish the work of RNs. In fact, several (4), respondents reported anecdotal incidents within their comments describing incorrect vital sign assessments performed by UAP. These are the kinds of questions regarding practice which professionals must address. If vital signs reported by UAP are not acceptable for practice they should not be delegated. A clear description of UAP functions must be written by nurses and administrators and ongoing assessments and corrective education for UAP performance must be routinely carried out.

Responses to ancillary questions, 151 - 159 were thought provoking. Thirty-five of the 48 faculty respondents reported that they have first

hand experience with UAP. One reported that she had more time to supervise her nursing students than to supervise her technical partners at work which she concluded was an inadequate situation not to her liking. Another, contributed that several students held positions as UAP and had multiple horror stories to tell.

Many of the faculty, 27 or 56%, felt that UAP should be certified and 31 or 65% desire state registration of UAP. Almost all respondents, 41 or 86%, were in favor of program evaluation by objective, out of institution evaluators, such as the National League for Nursing and State Boards of Nursing.

In response to the question about placing one year certificate programs for UAP education within community colleges twenty-two said yes and eighteen said no. Several people, eight, wrote that they thought six months is a more appropriate amount of time and two people said certification, registration and/or college was "too good" for the UAP, indicating a degree of hostility.

Summary comments on the survey from faculty underscore the stark findings. A total of thirty-six or 76% of the respondents wrote comments within the body of the survey or at the end in the comment area. Most voiced alarm at the expanded role, complained about the inadequacy of training the UAP received, demanded that our professions set standards for performance, and wondered at the integration of these six week wonders when the patient acuity has risen sharply while the length of patient stays has dropped.

One respondent was in favor of unlicensed personnel. She was also in favor of eliminating diploma and associate degree education stating that it is ridiculous for ADN to manage units and suggested that the ADN become the Licensed Practical Nurse. Six respondents pointed out that the LPN and ADN nurses were specifically educated to be the technical assistive personnel for RNs. In the literature, Manual and Alster also argue that the Associate Degree Nurse (ADN) was the one educated to take the role of assistant to the baccalaureate prepared nurse (BSN). Other educators, Forsey, Cleland and Miller, agree and call upon health care employers to utilize the ADN graduate according to the role described by Montag rather than creating positions for less skilled workers. The advantages for using the ADN are that there is a clear, established role; the ADN is licensed; and the ADN has a well established record in nursing

practice. The disadvantages of using UAP is that nurses are not well educated in delegating to and supervising UAP; the time needed to supervise UAP may be more than anticipated and increase the stress on the nurse who must be responsible for greater numbers of patients. Most importantly, nurses and nurse educators, judging by the Blegen, Ball and Goldstone studies and this survey, do not trust UAP to carry out the assigned tasks safely and express anxiety at being forced to delegate when patient assignments are increased.

Conclusions and Recommendations:

The challenge for nursing is to clearly delineate those tasks which are safe to delegate to UAP, incorporate decision models for practice within nursing education, require oversight of the education and practice of UAP, set limits on the utilization of UAP, work for establishing safe patient - nurse ratios within acute and long-term care situations, and assiduously seek creative and effective health care cost reductions.

A firm and united presentation by the nursing profession regarding the education of UAP and the integration of UAP within the health care system is essential because if nurses don't set the standards an administrator or managed care executive will. Rezler and Stevens (10), nurse educators, write that in general there are "many difficulties in obtaining agreement among educators regarding educational objectives". Judging by this survey and the literature there is a great deal of consensus among working RNs and nurse educators; traditional aides are welcome UAP are not. This consensus is empowerment for nurses because they are the only ones, by law, who can delegate nursing tasks.

Rezler and Stevens (10) continue; ...in order to provide acceptable and cogent objectives for any program of learning "all persons involved", students, educators, employers, consumers and managers/evaluators must be included in the process of setting goals. Therefore, nurses must enlist the help of the patient consumer, public officials, regulating organizations, as well as other health care professionals so that programs for education of all health care personnel is productive, safe and appropriate.

Community colleges are in an excellent position to respond to the changing community needs for restructured allied health educational programs.

Task forces within the college comprised of allied health educators and community advisors can formulate continuing education programs and flexible curricula which include management, leadership and multiple skills training so that students and graduates of nursing and allied health programs can be equipped with the information and skills needed for the changing work world.

By working in association with community and educational leaders, the message that patient care carried out by unlicensed, under-educated people is a dangerous and more costly proposition than looking for cost controls in other areas, can be communicated directly.

The recommendations gleaned from the literature and survey results also suggest that a great deal of empirical and observational research is needed to evaluate educational programs which utilize "on the job" training for UAP, and patient outcomes where UAP are providing care. Hospitals and managed care executives must prove to the public that: infection rates will remain low when unlicensed persons perform sterile procedures; early discharge and limited time with nurses will not increase readmissions to the hospital because of inadequate self-care; costs are reduced when training costs and high rates of absenteeism and turnover for UAP are factored into budgets; and patients entering the hospital can expect to spend a reasonable amount of time with their primary nurse, each shift, because the nurse-patient ratio is appropriate and not the 15 or 17 to one described in the management literature.

Nursing professionals relying on studies in the nursing literature which point to positive outcomes associated with high proportions of RN staff as measured by decreased mortality rates and fewer complications during hospitalization (Hartz et al. Krakauer et al., and Mitchel et al.), oppose the introduction of large numbers of UAP. They argue that if the hospitals and managed care firms truly desire flexible, high quality, multiskilled professionals the answer is not to employ untrained individuals but to utilize the traditional aide LPN, ADN, BSN and other allied health professionals according to the roles for which they have been educated. New tasks can be introduced according to each worker's educational preparation and abilities.

As this writer sees it, if nurses are replaced by UAP there are two tragedies in the making: one, the lowering of patient care standards and

two, the emotional and economic exploitation of the UAP who are assigned to carry out complex tasks after only eight weeks of education. Who will console those patients, families and UAP when things go terribly wrong? Don't count on the bottom line money managers because they'll cut their losses and run.

The nursing profession has a duty to monitor changing roles within health care systems and to draw the line to ensure safe patient care. So, raise the flag, beat the drums, write letters, make speeches, join forces with your fellow nurses and get the message out to the world, that the bottom line for nurses is safe and economical health care. Nurses must organize so our profession's voice is clear. Use the words of Florence Nightingale: **"...there is no such thing as amateur nursing" (Montiero).**

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APPENDIX

Jane Pamela Meehan
530 Linwood Avenue
Ridgewood, New Jersey
07450
(201) 447-1214

Dear Colleague;

These are difficult times for the nursing profession. In response to economic pressures health care administrators throughout the country are employing Unlicensed Assistive Personnel (UAP) in direct replacement of registered nurses (RN). Reading the management journals one can see the goals clearly stated: reduction in RNs to 40% to 60% of staffs from 70% to 80%.

Currently the National Council of State Boards of Nursing is conducting a survey of its members requesting the members input on appropriate tasks to delegate to UAPs by RNs. It is my contention that nurse educators, who have no economic relationship and less political ties with clinical agencies, should be the population which establishes guidelines for the delegation of tasks to UAPs.

The survey enclosed is based upon those skills designated as traditional and non-traditional or extended in the literature. The results of this survey will be shared with the New Jersey State Board of Nursing. The data will inform educators who will be designing learning modules for nursing students relative to the safe delegation of tasks to UAPs.

Please spend the 20 - 30 minutes necessary to fill out the enclosed questionnaire. I have enclosed a stamped, self-addressed envelope for your convenience. The deadline for my research is in May so a quick response is essential.

I thank you in advance for your help. The results of the study will be made available upon request.

Very truly yours;

Jane Pamela Meehan
Associate Professor
Bergen Community College
400 Paramus Road
Paramus, New Jersey 07652
(201) 447-7181

April, 1995

DEFINITIONS FOR SURVEY:

Unlicensed Assistive Personnel: individuals who may be entitled aid, technician, orderly etc. These persons are unauthorized to perform nursing actions unless delegated by a registered nurse. The educational programs for unlicensed personnel is not uniform but usually consists of six to eight weeks of training. Basic educational requirements for the unlicensed assitive position is a high school degree or equivalent. Abbreviation UAP.

Registered Nurse: a licensed professional nurse who may delegate nursing tasks to an individual who is known to possess the knowledge and skill to carry out the task safely. The registered nurse is responsible and accountable for all nursing care rendered and for the supervision and evaluation of the individual performing the task. Abbreviation RN.

Registered Professional Nursing: According to the New Jersey Nurse Practice Act (pg. 16) "...professional nursing is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and well-being, and executing medical regimen as prescribed by a licensed or otherwise legally authorized physician or dentist. Diagnosing in the context of nursing practice means the identification of and discrimination between physical and psychosocial signs and symptoms essential to effective execution and management of the nursing regimen. Such diagnostic privilege is distinct from a medical diagnosis. Treating means selection and performance of those therapeutic measures essential to the effective management and execution of the nursing regimen. Human response means those signs, symptoms and processes which denote the individual's health need or reaction to an actual or potential health problem."

Knowledge: cognitive and psychosocial abilities necessary to complete a delegated task successfully and safely. This implies formal education and evaluation by a registered nurse educator.

Skills: psychomotor abilities necessary to carry out a delegated task successfully and safely. This implies formal education, practice and evaluation by a registered nurse educator.

Delegation: directing a UAP to carry out a specific task which the nurse defines, supervises, evaluates. It is the responsibility of the nurse to know that the task delegated is within the UAP's ability. The nurse is accountable for all care rendered by the UAP.

Supervision: guidance and support provided by a qualified registered nurse so that a UAP can accomplish an assigned task. This implies clear directions to initiate and complete any task delegated; checking periodically on the task performance; inspection of the completed task; and evaluation and corrective education of the UAP when necessary. The registered nurse remains accountable for all nursing care rendered and must establish a continuing evaluation process for those UAPs supervised.

Accountability: Being legally liable or answerable for an action.

APPENDIX

NURSING TASKS WHICH ARE SAFE TO DELEGATE TO UNLICENSED ASSISTIVE PERSONNEL:
A Survey of Associate Degree Nursing Program Educators in New Jersey

Directions: Please designate by placing an X in the Yes or No column those tasks which you consider safe to delegate to an unlicensed assistive person (UAP). According to the Nurse Practice Act registered nurses are responsible for all nursing care provided to patients even those delegated to others. When making your decisions choose tasks on the basis of the complexity of knowledge inherent in the task itself.

Assume for this study that all tasks are taught by a registered nurse during a training program and that those tasks delegated:

1. are routinely performed in the daily care of the patient;
2. are clearly organized into an accepted sequence of steps;
3. are performed with the expectation of a specific, defined outcome;
4. do not require continuing or changing assessments or decisions which are beyond the task itself;
5. have been validated by the RN as within the abilities of the unlicensed person.

Comments are welcome.

TASK	DESIGNATION:	RAW SCORES Yes	No
I. Traditional Assistive Role			
A. Non-Patient Activities:			
1. bed making		Yes 48	No 00
2. clean patient unit post discharge		Yes 48	No 00
3. stock patient supplies		Yes 47	No 01
4. clean halls, floors, surfaces etc.		Yes 46	No 02
5. stock towels, soap, in unit storage areas		Yes 46	No 02
6. remove soiled linen and trash		Yes 48	No 00
7. transport specimens to lab		Yes 48	No 00
8. obtain equipment for unit		Yes 48	No 00
9. secretarial maintenance of charts eg. file reports etc.		Yes 48	No 00
10. secretarial recording TPR, I & O, Weight		Yes 47	No 01
11. secretarial transcribing of orders from chart which will be checked by RN		Yes 41	No 07
12. answer phone except for doctor orders		Yes 46	No 02
13. schedule tests etc. for patients		Yes 41	No 07
14. direct visitors on the unit		Yes 48	No 00
B. Patient Care:			
Hygiene:			
15. administer bed bath - adult		Yes 45	No 03
16. administer baby bath		Yes 38	No 10
17. administer sitz bath		Yes 38	No 10
18. administer tub bath		Yes 45	No 03
19. administer oral care		Yes 46	No 02
20. administer hair care/shampoo		Yes 47	No 01
21. administer nail care		Yes 43	No 05
22. assist with dressing/undressing		Yes 48	No 00

TASK	DESIGNATION: Yes	No
Nutrition:		
23. deliver trays	Yes 47	No 01
24. assist with feeding	Yes 46	No 02
25. record intake	Yes 45	No 03
26. offer fluids/restrict fluids	Yes 42	No 06
27. offer between meal snack/fluids	Yes 47	No 01
28. collect menus	Yes 47	No 01
Elimination:		
29. assist to bathroom/commode	Yes 47	No 01
30. assist with bedpan/urinal	Yes 47	No 01
31. collect routine specimens	Yes 42	No 06
32. administer perineal care	Yes 42	No 06
33. administer foley/suprapubic catheter care	Yes 27	No 21
34. empty drainage from foley bag	Yes 43	No 05
35. empty wound drainage from Jackson-Pratt	Yes 15	No 33
36. empty wound drainage from Hemovac	Yes 14	No 34
37. apply Texas catheters	Yes 38	No 10
38. administer tap water/saline/SSE	Yes 22	No 26
39. administer Fleets enema	Yes 29	No 19
40. administer douches	Yes 23	No 25
41. insert rectal tubes	Yes 20	No 28
42. maintain gastric suction - set up equipment	Yes 31	No 17
43. maintain gastric suction - change tubing	Yes 29	No 19
44. maintain gastric suction - empty drainage	Yes 32	No 16
45. measure/record emesis	Yes 41	No 07
46. measure/record stools	Yes 43	No 05
47. measure/record urine output	Yes 44	No 04
48. measure/record wound drainage	*Yes 21	No 26
49. weigh diapers/dressing to obtain output	Yes 38	No 10
Mobility:		
50. turn and position patients	Yes 44	No 04
51. transfer patient to chair/ tretcher	Yes 48	No 00
52. use slide boards	Yes 45	No 03
53. use pull sheets	Yes 46	No 02
54. use mechanical lift devices	Yes 43	No 05
55. get patient out of bed after initial time	Yes 47	No 01
56. walk patient with aids after patient received instruction/supervision/practice with walker	Yes 47	No 01
57. walk patient with cane(s)	Yes 44	No 04
58. walk patient with brace(s)	Yes 44	No 04
59. walk patient with crutches	Yes 43	No 05
60. perform range of motion exercises	Yes 30	No 18
61. apply sling	Yes 32	No 16
62. apply venodine boots	Yes 31	No 17
Safety:		
63. check/place side rails up	Yes 48	No 00
64. answer/place patient call lights	Yes 48	No 00
65. apply restraints	Yes 25	No 23
66. hold certification CPR/basic life support	Yes 46	No 02
67. hold certification Heimlich maneuver	Yes 47	No 01
68. perform appropriate handwashing	Yes 47	No 01

* Denotes one or more omitted responses.

TASK	DESIGNATION: Yes	No
Safety cont.:		
69. appropriate use of clean gloves	Yes 47	No 01
70. employ Universal Precautions	Yes 48	No 00
71. isolation: use of hat, mask and gown	Yes 41	No 07
72. sterile gloves	Yes 27	No 21
73. dispose of soiled equipment	Yes 46	No 02
Special Procedures:		
74. assess and record/report temperature (oral, rectal, axillary)	Yes 44	No 04
75. assess and record/report radial pulse	Yes 45	No 03
76. assess and record/report apical pulse	Yes 28	No 20
77. assess and record/report respirations	Yes 45	No 03
78. assess and record/report height	Yes 46	No 02
79. assess and record/report weight	Yes 46	No 02
80. assess weight using a baby scale	Yes 42	No 06
81. assess weight using bed scale	Yes 42	No 06
82. assess weight using standing/chair scale	Yes 45	No 03
83. remind patient to cough and deep breathe	Yes 40	No 08
84. apply warm soaks	Yes 20	No 28
85. apply aqua-K pad (temp. set by RN)	Yes 26	No 22
86. apply ice bag/compress	Yes 30	No 18
87. apply heating pad/hot water bag	Yes 21	No 27
88. provide backrub/skin massage	Yes 45	No 03
89. apply specific creams to intact skin	Yes 43	No 05
90. apply sheepskin/air mattress to bed	Yes 45	No 03
91. decubitus care - clean dressings/duoderm	Yes 10	No 38
92. apply wet to dry dressings	Yes 10	No 38
93. perform surgical skin prep/scrubs	Yes 32	No 16
94. apply support/ace bandages	Yes 24	No 24
95. apply TED stockings	Yes 39	No 09
96. apply abdominal binder	Yes 33	No 15
97. provide Postmortem care	Yes 43	No 05
II. Non-traditional Extended Assistive Role		
Oxygen:		
98. apply pulse oximeter	Yes 30	No 18
99. monitor pulse oximeter	Yes 09	No 39
100. set up oxygen equipment/wall units	Yes 34	No 14
101. monitor flow rate of oxygen	Yes 21	No 27
102. assess blood pressure	Yes 32	No 16
103. apply/remove EKG leads	Yes 34	No 14
104. EKG readings/tracing/monitoring	Yes 09	No 39
105. draw venous blood specimen	Yes 17	No 31
106. perform oropharyngeal suctioning	Yes 14	No 34
107. perform nasopharyngeal suctioning	Yes 09	No 39
108. change tracheostomy dressing	Yes 03	No 45
109. cleanse tracheostomy incision	Yes 03	No 45
110. change inner cannula	Yes 03	No 45
111. perform tracheal suctioning	Yes 01	No 47
Nutrition:		
112. perform oral/nasogastric feedings (placement verified by RN)	Yes 16	No 32

TASK	DESIGNATION: Yes	No
Nutrition cont.:		
113. perform gastrostomy feedings	Yes 16	No 32
114. clamping tubes (foley, N.G, G.I.)	Yes 27	No 21
115. remove oral/nasogastric feeding tubes	Yes 12	No 36
116. I.V. fluid - assemble and prime tubing	Yes 10	No 38
117. monitor flow rate of I.V. infusion	Yes 09	No 39
118. I.V. site care/dressing - peripheral line	Yes 04	No 44
119. I.V. site care/dressing - central line	Yes 02	No 46
120. discontinue peripheral line	Yes 11	No 37
121. discontinue central line	Yes 03	No 45
122. do finger stick for capillary glucose level	Yes 12	No 36
Elimination:		
123. perform urinary catheterization	Yes 03	No 45
124. irrigate urinary tubes	Yes 03	No 45
125. obtain sterile urine specimen from catheter	Yes 13	No 35
126. perform ostomy care	Yes 22	No 26
127. irrigate ostomies	Yes 06	No 42
128. break-up/remove fecal impactions	Yes 09	No 39
Psychosocial:		
129. care for acutely anxious patient	*Yes 12	No 35
130. care for patient on suicide observation	*Yes 22	No 25
131. care for confused patient in restraints	*Yes 27	No 20
132. care for patient in quiet room/locked seclusion	*Yes 23	No 24
Special Procedures:		
133. set-up/apply hypothermia blanket	Yes 19	No 29
134. apply sterile dressing/clean 48 hour old wound	Yes 07	No 41
135. apply sterile dressing/an infected wound	Yes 03	No 45
136. apply sterile dressing/complex wound/with medication	Yes 03	No 45
137. irrigate sterile wound	Yes 03	No 45
138. administer adult oral, routine, meds	Yes 02	No 46
139. administer an initial oral med	Yes 01	No 47
140. administer meds to infant/child patients	Yes 02	No 46
141. administer meds to elderly patients	Yes 03	No 45
142. administer IM. and Sq. meds	Yes 02	No 46
143. administer IVPB meds via peripheral line	Yes 01	No 47

III. Nursing practice questions

A. When administering the following drugs would you use a UAP's assessment in place of your own? Place a Yes or No next to each drug category.

144. antipyretic (temperature)	Yes 35	No 13
145. antiarrhythmic (apical rate and/or EKG)	Yes 01	No 47
146. analgesic (description of pain)	Yes 09	No 39
147. antihypertensive (blood pressure)	Yes 08	No 40
148. hypoglycemic (finger stick glucose)	Yes 14	No 34
149. antiemetic (complaint of nausea/vomiting)	Yes 20	No 28
150. anticoagulant (testing of blood for activated thromboplastin time with unit machine)	*Yes 04	No 42

* Denotes one or more omitted responses.

B. Educational Questions

151. Do you have a module in your curriculum which addresses delegation of tasks to UAPs? Yes 1 No 12

If yes please describe briefly.

One school has a module, two are planning a module and the rest do not have one.

152. Do you teach leadership principles to your students?
Yes All No

If yes please describe briefly.

All schools have a module which includes leadership and descriptions of primary nursing.

153. Do you teach primary and/or team nursing models in your program?
Yes All No

If Yes please describe briefly.

All thirteen schools teach primary model.

154. Are any of the agencies your program utilizes for student affiliation employing unlicensed assistive personnel/patient care technicians?
*Yes 35 No 10

If yes please describe briefly.

Mix of traditonal aids with UAP.

155. Who should teach the unlicensed assistive personnel/patient care technicians? (select all who you deem appropriate)

RN 23 RNC 21 BSN 30 MSN 34 Other 02

Other = anyone who can teach psychomotor skills well.

156. Should there be national certification for UAPs?
*Yes 27 No 17

Several (3) said we don't want them!"

157. Should there be registration of UAPs by each state?
*Yes 31 No 10

Several (5) said too expensive or too high an honor!

158. Should there be accreditation of learning programs for UAPs with oversite by State Boards of Nursing and NLN? Yes 41 No 07

159. Would you favor a one year certificate program within your community college? *Yes 22 No 18

Several (8) stated it should be no longer than 6 months.

IV. Demographic Data

160. Age: Range: 32 - 65; Average age: 45.3 Median age: 48

161. Sex: Male: 1; Female: 47

162. Faculty Rank: Instructor: 5; Asst. Prof.: 20; Assoc. Prof.: 18 Prof.: 4. *One no response.

163. Highest Degree earned: BSN: 1; MA/MSN: 39; Doctorate: 7; *one no response.

164. Area of concentration - teaching: Med/Surg 22; Peds 9; Obs 9; Psych 8; Total N = 48.

165. Area of concentration - practice: All areas were represented along with subspecialties: orthopedics; ICU, Home Health, and emergency.

166. Years of teaching nursing: Range: 2 - 40 Average: 15.75 Median: 19.

167. practice: Range: 3 - 40 Average: 21.6 Median: 19.

V. Comments: